SEP 19 '00 08:34AM CO... S PLUS...

BWC

First Report of an Injury, Occupational Disease or Death

WARNING: Any person who knowingly makes a false statement, misrepresentation ... to which ... is subject to felony criminal prosecution for fraud.

EXHIBIT 3

For faster service

00564734

Complete as much of all four sections of this form as possible. Type or print in black or blue ink. (R.C. 29 (3.48))

Injured Worker Info

Last Name, First Name, Middle Initial	Ferguson, David E.
Social Security Number	271-49-5561
Marital Status	☐ Single ☒ Married ☐ Divorced ☐ Separated ☐ Widowed
Date of Birth	9-27-49
Home Mailing Address	5885 Lawrenceburg Road
Sex	☒ Male ☐ Female
Number of Dependents	1
City	Harrison
State	OH
9-digit ZIP Code	45030
Country if different than USA	
Department Name	trucking
Wage Rate	$ 154.56 Per ☐ Hour ☐ Month ☐ Week ☐ Year ☒ Other day
What days of the week do you usually work?	☐ Sun ☒ Mon ☒ Tue ☒ Wed ☒ Thur ☒ Fri ☐ Sat
Regular Work Hours	From various
Have you been offered or do you expect to receive payment for this claim from anyone other than the Ohio Bureau of Workers' Compensation or the employer?	☐ YES ☒ NO
Occupation or Job Title	truck driver
Telephone Number	513-202-0002
Work Number	1-800-456-7314

I am applying for recognition of my claim under the Ohio Workers' Compensation Act for work-related injuries that I did not purposely inflict. I request payment for compensation and/or medical expenses as allowable. Direct payment(s) to the providers of any medical services are authorized. I understand that I am allowing any provider who attends to, treats or examines me to release all medical, psychological, and/or psychiatric information that is related to my workers' compensation claim to the Ohio Bureau of Workers' Compensation, the Industrial Commission of Ohio, the employer listed in this claim, that employer's managed care organization, and any authorized representative.

Injured Worker Signature: [signature] Date: 9/11/2000

Injury, Disease, Death Info

Date of Injury/Disease	9-7-00
Time of Injury	10:15 ☒ AM ☐ PM
If fatal, give date of death	n/a
Date Last Worked	9-7-00
Date Returned to Work	have not
Accident Location (street address)	GM Plant, Springboro
Date Hired	1-29-85
State Where Hired	OH
Date Employer Notified	9-7-00
City	Morraine
State	OH
Was place of accident or exposure on employer's premises?	☒ YES ☐ NO

Description of Accident (Describe the sequence of events that directly injured the employee, or caused the disease or death): I was loading a vehicle on the top deck head ramp. I was on my knees hooking a chain and when I started to get up I put my left hand on the safety cable and it snapped causing me to fall to the ground.

Type of Injury/Disease and Part(s) of Body Affected (For example: sprain of lower left back, etc.): Lower back- numbness and tingling left leg. My leg also throbs and is painful.

Treatment Info

Physician/Health-Care Provider Name	MARTIN L. McTighe, MD
Telephone Number	(513) 541-5522
Fax Number	(513) 541-5568
Initial Treatment Date	
Street Address	2450 Kipling Ave #205
City	Cincinnati
State	OH
9-digit ZIP Code	45239
Diagnosis(es): Include ICD-9 Code(s)	lumbar strain 847.2; [illegible] 724.3
Is this injury causally related to the industrial incident?	☒ YES ☐ NO
Provider Signature	[signature]
BWC Provider Number	227400910-00
Date	9-15-00

Employer Info

Employer Name	Allied Systems
Policy Number	
	☐ Employer is Self-Insuring ☐ Injured Worker is Owner/Partner/Member of Firm
Mailing Address (Number and Street, City or Town, State, and ZIP Code)	PO Box 1025, Decatur GA 30031
County	
Location, if different from mailing address	
Manual Number	
Telephone Number	(888) 849-8076
Fax Number	(404) 687-5752
Federal ID number	

☒ **CERTIFICATION** - The employer certifies that the facts in this application are correct and valid.

☐ **REJECTION** - The employer rejects the validity of this claim for the following reason(s) below:

☐ **CLARIFICATION** - The employer clarifies and allows the claim for the condition(s) below:

RECEIVED

AAG-RM

2000 ... -8 PM ... BUREAU RECEIVED WORKERS' COMP

Employer Signature and Title: Russell C. Figures Date: 10/23/00

OSHA Case Number:

ATT Russel Figures

Allied Automotive Group
An Allied Holdings Company
Risk Management

(317)

OHW 00003113/01
ss# 291-48-5861

October 23, 2000

Bureau of Workers' Compensation
125 East Court Street, 6th Floor
Cincinnati, Ohio 45202

Dear Claims Examiner:

RE: Insured: Allied Systems, LTD
Employee: Dave Ferguson
Date of Injury: 9/7/00

Allied Systems LTD is certifying the industrial injury occurring on 9/7/00 for the above captioned employee. The allowed conditions for this claim will be as follows:

847.02 - lower back strain
724.03 - sciatica

Attached is a completed FROI - 1 form.

Please let me know if you have any questions or if I can be of further assistance.

Sincerely,

Russell G. Figures
Claims Adjuster

Attachments

P. O. Box 1025 • Decatur, Georgia 30031-1025
404-371-0379
Workers' Comp: 888-849-8076 • Fax (404) 687-5752
Liability: 800-204-9941 • Fax (404) 370-4249